12. b. Dentures

i. Dentures provided by a participating Dentist on the basis of the lower of: actual charges; or the Department's Medical Assistance Unit statewide fee schedule.

ii. Payment for dentures provided by an Idaho Licensed Denturest will be based on maximum payment level established by the Department's Medical Assistance Unit or the amount billed, whichever is less. These providers will use the same procedure codes as Dentists.

c. Prosthetic Devices

i. Prosthetic and Orthotic - Services are reimbursed using the lower of the provider's actual charge for the service; or the maximum allowable charge for that device as established by the Department's Medical Assistance Unit pricing file.

ii. Hearing Aids - Payment is made to hearing aid vendors at usual and customary rates; or the maximum allowable charge as established by the Department's Medical Assistance Unit pricing file.

d. Eye Glasses - Payments to providers for eye glasses are made at the lower of: the usual and customary charges; or the Department's Medical Assistance Unit established fee schedule.

13. d. Rehabilitation Services - The rate of reimbursement for each component of ambulatory services included in the State's Medicaid Plan will be established by the Department's Medical Assistance Unit. This reimbursement rate will not exceed the usual and customary charges for comparable services under comparable circumstances in public and private agencies in the State of Idaho.

14. Services for individuals age 65 or older in institutions for mental diseases;

b.& c. Skilled Nursing Facility Services - Refer to Attachment 4.19D.

15. a. & b. Intermediate Care Facilities for the Mentally Retarded - Refer to Attachment 4.19D.

17. Nurse Practitioner/Nurse Midwives
Obstetrical Services

Nurse Practitioners/Nurse Midwives - The rate of payment for these providers will be at the maximum payment level established by the Department or the amount billed, whichever is less. These providers will use the identical procedure codes as the physicians and will have individual provider numbers.

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Nurse Practitioners

Procedure Code	SFYE MAXIMUM PAYMENT	Procedure Code	SFYE MAXIMUM PAYMENT	Procedure Code	SFYE MAXIMUM PAYMENT
59000	NA	59852	NA	99401	$8.67
59012	NA	59855	NA	99402	$17.32
59015	NA	59856	NA	99403	$25.99
59020	$44.07	59857	NA	99404	$34.64
59025	$31.65	59870	NA	99411	NA
59030	$40.12	59899	NA	99412	NA
59050	NA	99201	$23.49	99420	NA
59051	NA	99202	$32.46	99429	BY REPORT
59100	NA	99203	$42.01	99432	$64.11
59120	NA	99204	$56.54	90700	$23.00
59121	NA	99205	$65.97	90701	$17.23
59130	NA	99211	$18.85	90702	$6.33
59135	NA	99212	$24.20	90703	$4.00
59136	NA	99213	$28.27	90704	$18.25
59140	NA	99214	$37.70	90705	$17.55
59150	NA	99215	$56.54	90706	$17.55
59151	NA	99241	$33.24	90707	$35.00
59160	NA	99242	$43.66	90708	$22.30
59200	NA	99243	$52.06	90709	$23.32
59300	NA	99244	NA	90710	NA
59320	NA	99245	NA	90711	$33.00
59325	NA	99271	NA	90712	$16.22
59350	NA	99272	NA	90713	$18.00
59400	$1,039.78	99273	NA	90714	$3.00
5940P	$938.31	99274	NA	90716	$46.00
59409	$567.11	99275	NA	90717	$38.00
59410	$659.72	99341	$33.03	90719	$5.00
59412	NA	99342	$40.29	90720	$38.00
59414	NA	99343	NA	90721	$45.00
59425	$230.90	99351	$22.61	90724	$8.00
59426	$318.13	99352	$33.24	90725	$5.00
59430	$112.52	99353	$44.33	90726	$185.00
59510	NA	99354	$53.73	90727	$4.00
59514	NA	99355	$26.87	90728	$5.00
59515	NA	99358	NA	90730	$63.00
59525	NA	99359	NA	90732	$15.00
59812	NA	99381	$45.94	90733	$11.00
59820	NA	99382	$45.94	90737	$18.68
59821	NA	99383	$45.94	90741	BY REPORT
59830	NA	99384	$56.60	90742	BY REPORT
59840	NA	99391	$31.78	90744	$26.00
59841	NA	99392	$31.78	90745	$42.00
59850	NA	99393	$34.69	90749	BY REPORT
59851	NA	99394	$46.35	Q0158	$35.85

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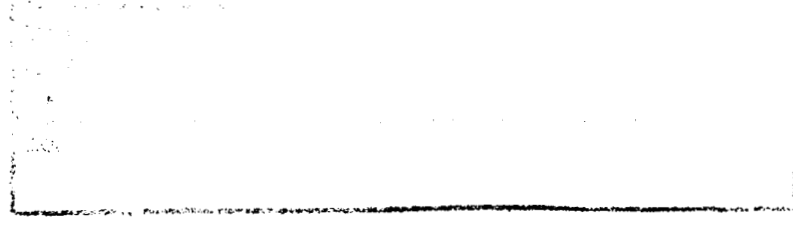
18. Hospice Services With the exception of payment for physician services, Medicaid reimbursement for hospice care will be made at one (1) of four (4) predetermined rates for each day in which an individual receives the respective type and intensity of the services furnished under the care of the hospice. The four (4) rates are prospective rates, there will be no retroactive rate adjustments other than the application of the "cap" on overall payments and the limitation on payments for inpatient care, if applicable. A description of the payment for each level of care is as follows:

A. Routine home care - The hospice will be paid the routine home care rate for each day the patient is in residence, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

B. Continuous home care - Continuous home care is to be provided only during a period of crisis. A period of crisis is the period in which a patient requires continuous care which is primarily nursing care to achieve palliation and management of acute medical symptoms. Care must be provided by either a registered nurse or a licensed practical nurse and a nurse must provide care for at least half the total period of care. A minimum of eight (8) hours of care must be provided during a twenty-four (24) hour day which begins and ends at midnight. This care need not be continuous and uninterrupted. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to twenty-four (24) hours per day.

C. Inpatient respite care - The hospice will be paid at the inpatient respite care rate for each day that the recipient is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of five (5) days including the date of admission but not counting the date of discharge in any monthly election period. Payment for the sixth and any subsequent day is to be made at the appropriate rate routine, continuous, or general inpatient rate.

D. General inpatient care - Payment at the inpatient rate will be made when general inpatient care is provided. No other fixed payment rates will be applicable for a day on which the recipient receives hospice general in patient care except as described in the section of this plan which discusses payment of physician services.



18. Hospice Care (continued)

E. Other General Reimbursement Items

i. Date of Discharge - For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged as deceased, the inpatient rate, either general or respite, is to be paid for the discharge date.

ii. Hospice payment rates. The Medicaid hospice payment rates are the same as the Medicare hospice rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. Under the Medicaid hospice benefit, no cost sharing may be imposed with respect to hospice services rendered to Medicaid recipients.

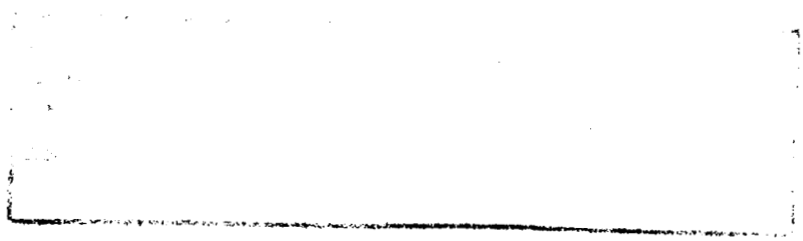
F. Obligation of Continuing Care - After the recipient's hospice benefit expires, the patient's Medicaid hospice benefits do not expire. The hospice must continue to provide that recipient's care until the patient expires or until the recipient revokes the election of hospice care.

G. Limitation on Payments for Inpatient Care - Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the twelve (12) month period beginning November 1 of each year and ending October 31 of the next year, the aggregate number of inpatient days (both general inpatient days and inpatient respite care) may not exceed twenty percent (20%) of the total number of days of hospice care provided to all Medicaid recipients during the same period by the designated hospice or its contracted agent(s).

i. For purposes of computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitations on payment for inpatient days are as follows:

(a) The maximum number of allowable inpatient days will be calculated by multiplying the total number of a provider's Medicaid hospice days by twenty percent (20%).

(b) If the total number of days of inpatient care to Medicaid hospice patients is less than or equal to the maximum number of inpatient days computed, then no adjustment is made.



(c) If the total number of days of inpatient care exceeds the maximum number of inpatient days computed, then the payment limitation will be determined by:

(1) Calculating the ratio of the maximum allowable inpatient days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care that was made.

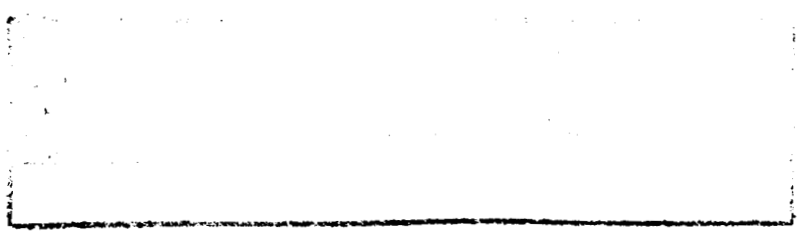
(2) Multiplying excess inpatient care days by the routine home care rate.

(3) Adding the amounts calculated in paragraphs (1) and (2).

(4) Comparing the amount in paragraph (3) with interim payments made to the hospice for inpatient care during the "cap period".

(d) The amount by which interim payments for inpatient care exceeds the amount calculated in section (c) (4) is due from the hospice.

H. Payment for Physician Services - The basic rates for hospice care represent full reimbursement to the hospice for the costs of all covered services related to the treatment of the recipient's terminal illness, including the administrative and general activities performed by physicians who are employees of or working under arrangements made with the hospice. These activities would generally be performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care.



i. Reimbursement for a hospice employed physician's direct patient services which are not rendered by a hospice volunteer is made in accordance with the usual Idaho Medicaid reimbursement methodology for physician's services. These services will be billed by the hospice under the hospice provider number and, the related payments will be counted in determining whether the overall hospice cap amount has been exceeded. The only physician services to be billed by a hospice for such services are direct patient care services. Laboratory and x-ray services are included in the hospice daily rate.

ii. Volunteer physician services are excluded from Medicaid reimbursement with the following exceptions.

(a) A hospice may be reimbursed on behalf of a volunteer physician for specific direct patient care services which are not rendered on a volunteer basis. The hospice must have a liability to reimburse the physician for those services rendered. In determining whether a service is provided on a volunteer basis, a physician must not distinguish which services are provided voluntarily on the basis of the patient's ability to pay.

(b) Reimbursement for an independent physician's direct patient services which are not rendered by a hospice volunteer is made in accordance with the usual Idaho Medicaid reimbursement methodology for physician services. These services will not be billed by the hospice under the hospice provider number and they will not be counted in determining whether the overall hospice cap amount has been exceeded. The only services to be billed by an attending physician are the physician's personal professional services. Costs for services such as laboratory or x-rays are not to be included on the attending physician's billed charges to the Medicaid program. The aforementioned charges are included in the daily rates paid and are expressly the responsibility of the hospice.

H. Cap on Overall Reimbursement - Aggregate payments to each hospice will be limited during a hospice cap period. The total payments made for services furnished to Medicaid recipients during this period will be compared to the "cap amount" for this period. Any payments in excess of the cap must be refunded by the hospice.

18. Hospice Care (continued)

i. The overall cap will be compared to reimbursement after the inpatient limitation is computed and subtracted from total reimbursement due the hospice.

ii. "Total payment made for services furnished to Medicaid recipients during this period" means all payments for services rendered during the cap year, regardless of when payment is actually made.

iii. The "cap amount" is calculated by multiplying the number of recipients electing certified hospice care during the period by six thousand five hundred dollars ($6,500). This amount will be adjusted for each subsequent cap year beginning November 1, 1989, to reflect the percentage increase or decrease in the medical car expenditure category of the Consumer Price Index (CPI) for all urban consumers as published by the Bureau of Labor Statistics.

iv. The computation and application of the "cap amount" is made by the Department's Medical Assistance Unit after the end of the cap period.

v. The hospice will report the number of Medicaid recipients electing hospice care during the period to the Department's Medical Assistance Unit. This must be done within thirty (30) days after the end of the cap period as follows:

vi. If a hospice certifies in mid-month, a weighted average cap amount based on the number of days following within each cap period would be used.

I. Adjustment of the Overall Cap - Cap amounts in each hospice's cap period will be adjusted to reflect changes in the cap periods and designated hospices during a recipient's election period. The proportion of each hospice's days of service to the total numbered hospice days rendered to a recipient during their election period will be multiplied by the cap amount to determine each hospice's adjusted cap amount.

i. After each cap period has ended, the Department's Medical Assistance Unit will calculate the overall cap within a reasonable time for each hospice participating in the Idaho Medicaid Program.

ii. Each hospice's cap amount will be computed as follows:

(a) The share of the "cap amount" that each hospice is allowed will be based on the proportion of total covered days provided by each hospice in the "cap period".

(b) The proportion determined in Section (I) (2) (a) for each certified hospice will be multiplied by the "cap amount" specified for the "cap period" in which the recipient first elected hospice.

(c) The recipient must file an initial election during the period beginning September 28 of the previous cap year through September 27 of the current cap year in order to be counted as an electing Medicaid recipient during the current cap year.

J. Additional Amount for SNF and ICF Residents - An additional per diem amount will be paid for "room and board" of hospice residents in a certified SNF or a certified ICF receiving routine or continuous care services. In this context, the term "room and board" includes, but is not limited to, all assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies. The additional payments and the related days are not subject to the caps. The amount for room and board rate will be based per subsection 1902(a) (13) of the Social Security Act.